THE CHIROPRACTIC PLACE

Feel Better, Stay Better

Policies

1. Please note our typical fees for your initial visit:

Consultation:	Always Complimentary
Examination:	See front desk
Treatment:	See front desk

2. All fees are payable when services are rendered, unless prior arrangements have been made.

Please check which option you choose for paying for your care:

☐ **Medical Insurance:** If you have major medical insurance, please provide us with your insurance card. The Chiropractic Place does not bill major medical insurance directly (unless special arrangements have been made). Patients with major medical insurance may request "superbills" (we suggest quarterly); patients mail these superbills to their respective insurance company, and if chiropractic benefits are available, the patient will be reimbursed directly by his or her insurance carrier.

☐ **Medicare:** Per established Medicare guidelines please bring us your Medicare information by or before your second visit. We will bill your Medicare directly. In the event an insurance reimbursement check should come to you, you are expected to bring the check to us. **Please also refer to and sign the Medicare ABN form**.

☐ **Self-Pay:** Fees are to be paid at the time services are rendered, unless special arrangements have been made in advance.

I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I agree authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof.

By my signature, I understand that HIPAA Notice of Privacy Practices policies are posted, and a copy is available to me for review at any time.

Patient Name: _____

Signature: _____ Date: _____

In Case of Emergency:

Notify (print): _____ Address: _____

Relationship: _____ Phone: _____

[CONSENT TO EVALUATE AND TREAT A MINOR CHILD]

I, (print parent/guardian's name) _____, being the parent or legal guardian of (print child's name) _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care, including referral for X-rays, if deemed necessary.

Parent/Guardian Signature: _____ Date: _____

[WOMEN ONLY]

□ There is a chance I might be pregnant, and/or I do not wish to be referred for X-rays (check box).

Patient Signature: _____ Date: _____

TERMS OF ACCEPTANCE
CHIROPRACTIC INFORMED CONSENT

When a patient seeks chiropractic health care, and we agree to provide this care, it is essential for both patient and doctor to be working toward the same objective. It is important that each patient understand both the objective of chiropractic care, and the method with which the objective will be achieved. This prevents any confusion and/or disappointment.

Health: A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity (*Dorland's Medical Dictionary*).

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses. Since the human body is controlled and regulated by nerve impulses, this misalignment results in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any diseases or condition other than vertebral subluxation; however, if, during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of the appropriate health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY PRACTICE OBJECTIVE is to eliminate a major interference to the expression of the body's innate healing mechanism. Our only method is specific adjusting to correct vertebral subluxation.

Your orthopedist, family practitioner, or past chiropractor may have discussed with you various modalities of pain relief: drugs, surgery, physical therapy, manipulation, etc. We want to make you aware of how care works in this office, and what is available today thanks to progress in spinal health care.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine, by hand and by Sigma Instrument ProAdjuster instrumentation.

Adults: Chiropractic treatment can be successful at any age. The longer the subluxation has been there and the more damage that has been done, the longer it will take to correct and stabilize, and the more often you will need adjustments in order to maintain a healthy spine and nervous system.

Kids: Children's spines are very fragile, and improper alignment as a child can lead to permanent spinal impairment as they grow. Children get quick and profound results for a number of conditions clearly related to subluxation; therefore, it is best to check children for subluxation and begin any necessary treatment as young as possible. We encourage you to make chiropractic a part of your regular family health routine, much like going to the dentist.

Duration of Care: While pain relief may take only a few visits, getting well takes time. Depending on the patient's age, subluxation severity and lifestyle, adjustment and rehabilitative schedules for correction can range from weeks to years. Following correction, the doctor will make a recommendation for retainer care and lifetime maintenance.

As a rule, informed and cooperative patients can achieve positive chiropractic results. Thus, the following information is routinely supplied to all who consider chiropractic treatment. While recognizing the benefits of a healthy nervous system, you should also be aware that, like all areas of the healing arts, response to treatment and results cannot be guaranteed.

> **"Crisis" Care:** Most patients first consult us in this stage, when they are in pain, or have a detrimental symptom. We pride ourselves on efficient, effective care to produce the quickest results possible. Our years of experience tell us most patients will find relief of their symptoms in as few as three visits, to as many as 12 to 18. Results vary, depending on the severity of each patient's condition.
>
> **"Lifestyle" Care:** Once a patient has exited the "crisis" stage of care, a very important choice can be made whether or not to utilize routine chiropractic care. Much like going to a gym to improve and maintain fitness, spinal maintenance requires just that, maintenance. Routine chiropractic care, as part of a healthy lifestyle, will optimize the normal position of your spine and central nervous system. The gold standard for health care is to ensure the reduction of subluxation in the spine and then to maintain this for a lifetime.
>
> Do you see yourself choosing lifestyle routine chiropractic care, once your symptoms are resolved? ☐ Yes ☐ No ☐ Maybe

I, (print) _____, have read and fully understand the above statements.

I understand the doctor's objectives pertaining to my care in this office. I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____

Name _____ SSN (if no ID provided) _____

Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Date of Birth _____ Age _____ Height _____ Weight _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced Name of Spouse (or parent/guardian) _____

Employer _____ City/State _____ Occupation _____

How did you hear about us (whom may we thank for referring you)? _____

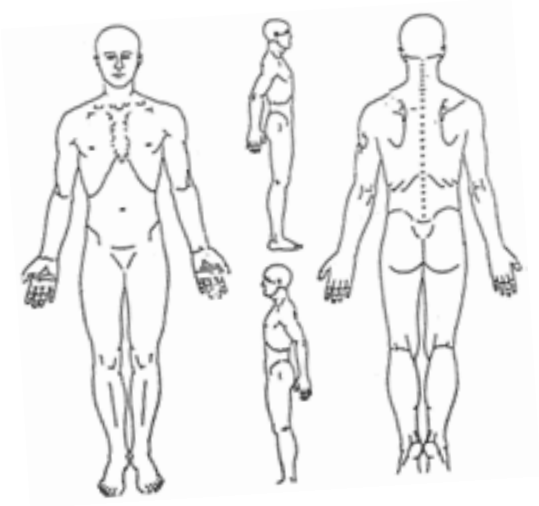
What is the name of your family physician? _____ City/State _____

Do we have your permission to contact your family physician to discuss your condition and treatment? ☐ YES ☐ NO

If you are experiencing any pain (neck pain, mid back pain, low back pain, etc.), health problems, symptoms, and/or complaints which brought you to our office, please list in order of severity.

1. _____ For how long? _____ Worse/Better? _____
2. _____ For how long? _____ Worse/Better? _____
3. _____ For how long? _____ Worse/Better? _____
4. _____ For how long? _____ Worse/Better? _____
5. _____ For how long? _____ Worse/Better? _____

COMPLETE THE BODY DIAGRAM



Use the following symbols to describe your symptoms on the body diagram:

x x x	Sharp Pain
+ + +	Numbness / Tingling
/ / / /	Throbbing
- - - -	Aching / Dull pain
O O O	Tightness / Stiffness

Is there anything specific you would like us to know about these symptoms?

_____

Have you ever had any surgeries, augmentations, or hospitalizations? ☐ YES ☐ NO

If yes, please list with dates: _____

Please list any current or past injuries and illnesses not listed above: _____

Please check all medications (over the counter and/or prescribed) you are currently taking:
☐ Aspirin / Tylenol ☐ Pain Killers ☐ Muscle Relaxers ☐ Insulin ☐ Birth Control Pills ☐ Sleeping Pills ☐ Anti-Depressants
☐ Others _____

Do you have any concerns about your overall health and well-being? (Sleeping, range of motion, stress/anxiety, digestion, skin, etc.)?

_____

Please check any of the following if they have applied or do apply to you (current or past):

General	**Muscle / Joint**	**Skin**
□ Allergies [Type: _____]	□ Arthritis / rheumatism	□ Boils
□ Depression	□ Bursitis	□ Bruise easily
□ Dizziness	□ Foot trouble	□ Dryness
□ Fainting	□ Muscle weakness	□ Hives or allergies
□ Fatigue	□ Low back pain	□ Itching
□ Fever	□ Neck pain	□ Rash
□ Headaches	□ Mid back pain	□ Varicose veins
□ Loss of sleep	□ Joint pain	
□ Mental illness		**Cardiovascular**
□ Nervousness	**Gastrointestinal**	□ High blood pressure
□ Tremors	□ Abdominal pain	□ Low blood pressure
□ Weight loss / gain	□ Colitis / Crohn's	□ Hardening of the arteries
	□ Colon trouble	□ Irregular pulse or heartbeat
Eye, Ear, Nose & Throat	□ Constipation	□ Pain over heart
□ Colds	□ Diarrhea	□ Palpitation
□ Deafness	□ Difficult digestion	□ Poor circulation
□ Earache	□ Diverticulosis	□ Rapid heartbeat
□ Eye pain	□ Bloated abdomen	□ Slow heartbeat
□ Hoarseness	□ Excessive hunger	□ Swelling of ankles
□ Nasal obstruction	□ Gallbladder trouble	
	□ Hernia	**Women only:**
Respiratory	□ Liver trouble	□ Irregular cycle
□ Chest pain	□ Nausea	□ Pain / Cramps
□ Chronic cough	□ Pain over stomach	□ Difficulty getting pregnant
□ Difficulty breathing	□ Poor appetite	□ Breast augmentation
□ Hay fever	□ Vomiting	□ Miscarriage
□ Shortness of breath		
□ Spitting up phlegm / blood		
□ Wheezing		
Past or Present History		
□ Alcoholism	□ Eczema	□ Meningitis
□ Anemia	□ Edema	□ Multiple sclerosis
□ Appendicitis	□ Emphysema	□ Mumps
□ Arteriosclerosis	□ Epilepsy	□ Nose bleeds
□ Asthma	□ Goiter	□ Numbness/tingling
□ Bronchitis	□ Gout	□ Pacemaker
□ Cancer	□ Heart burn	□ Sinus infection
□ Chicken pox	□ Heart disease	□ Sore throat
□ Cold sores	□ Hepatitis	□ Stroke
□ Diabetes	□ High cholesterol	□ Thyroid disease
□ Osteoporosis	□ HIV/AIDS	□ Tonsillitis
□ Pneumonia	□ Influenza	□ Tuberculosis
□ Polio	□ Malaria	□ Ulcers
□ Rheumatic fever	□ Measles	□ Vision problems

Previous Chiropractic Care: □ Yes □ No If Yes, date of last adjustment: _____

How often did you go?: _____ Did it help you?: □ Yes □ No

What type of care did you receive? (Circle all that apply): Pain Relief | Corrective | Manual | Activator | ProAdjuster

Reason for discontinued care: _____

What are some things you liked about it: _____

What are some things you did not like about it: _____

Check the chief problems/complaints/symptoms that brought you in today; circle the most bothersome (primary):

□ Neck Pain	□ Hip pain	Left or Right	□ Knee	Left or Right
□ Upper back pain	□ Shoulder	Left or Right	□ Ankle	Left or Right
□ Mid back pain	□ Wrist	Left or Right	□ Headaches	□ Migraines
□ Low back pain	□ Sciatica	Left or Right	□ Other: _____	

How did your condition develop? (Did it come on gradually/suddenly/unknown from an activity, event, or injury?):

_____

_____

When was the first time in your life you ever had the same or similar problem? Please Explain.

_____

_____

How often do you have these symptoms? (i.e. Constantly, daily, frequently, etc.):

_____

_____

Has your primary symptom/condition been **improving**, **worsening**, or **staying the same**? (Circle one)

How intense is your primary symptom, on a scale of 1 to 10, with 10 being the worst? _____

When it is at its worst, describe how it feels?

□ Sharp	□ Dull Ache	□ Burning	□ Annoyance	□ Heavy feeling	□ Debilitating
□ Stabbing	□ Deep Ache	□ Numbness	□ Weak	□ Throbbing	□ Stinging
□ Tingling	□ Pressure	□ "Zaps"	□ Shooting	□ No feeling at all	

Do your symptoms make any of the following activities of daily living difficult (circle all that apply):

Family/Home Responsibilities Work Recreation Social Activities Life Support/Self-Care Sleep

How do your symptoms affect your daily life / work / school / home / social activities? What do you wish were different?:

_____

_____

What kind of work do you do for a living; what do you put your body through? (Physical labor, desk job, travel, etc.):

_____

Signature: _____ Date: _____

Office Use Only: